Referral Form for Antibody Infusion for COVID

(**indicates required field)

Please complete this form in its entirety answering and including as much patient information as you can. Submit this form to the site closest to the patient. The Infusion Site team will review the referral form upon receipt and contact the patient to coordinate services as soon as possible. Please do not call or request preferential treatment as the team will triage and work to meet the needs of the patient with the limited dosing available. Thank you for your understanding.

Region 1: UPMC Western Maryland Hospital (Cumberland)	*Email form to WMD-COVIDantibody@upmc.edu*
Region 2: Meritus Regional Infusion Center (Hagerstown)	*Fax form to 301-790-9229*
Region 3: Baltimore Convention Center Field Hospital	*Go to umms.org/ICReferral to submit it via secure, HIPAA-compliant upload.*
Region 4: *TidalHealth Peninsula Regional (Salisbury)* *Atlantic General Hospital*	*Email form to COVIDTX@TidalHealth.org or* *Fax: 410-912-4959* *Call the Scheduling Line at 410-641-9714 or 410-641-9605 to schedule the patient* *Fax form to 410-641-9708*
Region 5: Adventist HealthCare Takoma Park Alternative Care Site Infusion Center	*Fax form to 301-891-6120*

**First Name: _____

**Last Name: _____

**DOB: _____ Age: _____ **Gender: ☐ M ☐ F ☐ Other _____ ☐ Unknown

**Patient's Preferred Language: ☐ English ☐ Spanish ☐ Other _____

**Address Line 1: _____

Address Line 2: _____

**City: _____ **State: _____ **ZIP: _____

County: _____

**Phone: Cell _____ Home _____

Secondary Phone: Cell _____ Home _____

Emergency Contact Name: _____

Emergency Contact Relationship: _____

Emergency Contact Phone - Cell _____ Home _____

Patient Name:_____ **DOB:** _____

Allergies (medication/food/other):

Include any additional information regarding patient's health history and medication history. You may free text, copy/paste, or you may attach a recent clinic note or other document that includes current problem list, health history (major surgeries, major illnesses), current medication list, and medication allergies.

Inclusion and Exclusion Criteria:

**Weight - lbs: _____ Kg: _____ **Height (ft/in): _____ BMI: _____

**Patient has had a recent SARS-CoV2 PCR Positive Test Result: ☐ Yes ☐ No
(Test must be first known positive test result.)

**SARS-CoV2 PCR test date (date specimen obtained): _____

****SARS-CoV2 symptom onset date (best approximation)**: _____
[Note: Bamlanivimab is approved for patients with mild to moderate COVID symptoms. Asymptomatic patients likely will not benefit and should not be referred.]

**Patient Symptoms (check all that apply):

☐ Fever ☐ Cough ☐ SOB ☐ Loss of taste/smell ☐ Malaise/fatigue
☐ Nausea/Vomiting ☐ Diarrhea ☐ Throat pain ☐ Congestion ☐ Myalgia
☐ Headache ☐ Other_____

**SpO_2: ____ (If < 94%, patient should be referred for hospitalization due to need for supplemental O_2 and thus would not be appropriate for Bamlanivimab treatment.)

☐ On RA or ☐ On chronic O_2 therapy – Baseline O_2 Flow rate: _____

Has the patient required an increase in O_2 flow rate since becoming symptomatic with COVID? ☐ Yes ☐ No

Patient Name: _____ **DOB:** _____

High Risk for Severe COVID Illness (check all that apply):

☐ Age ≥ 65 y/o

☐ BMI ≥ 35

☐ CKD Disease Stage _____ Baseline [Cr] _____

☐ Diabetes Mellitus ☐ Type II ☐ Type I

☐ Immunosuppressive Disease (e.g. leukemia, lymphoma, asplenia, neutropenia, AIDS if CD4 < 200, etc.)

☐ Specify: _____

☐ Immunosuppressive Treatment (e.g. chronic steroid, chemotherapeutic, biologic immunomodulator)

☐ Specify: _____

☐ Age ≥ 55 y/o *and:*

☐ Cardiovascular Disease/Specify (e.g. CAD, CVD, PVD, cardiomyopathy): _____

☐ HTN

☐ COPD

☐ Other Chronic Respiratory Disease (e.g. Pulmonary Sarcoid, Pulmonary Fibrosis)

☐ Specify: _____

☐ Age 12 – 17 y/o *and:*

☐ BMI ≥85th percentile for their age and gender based on CDC growth charts https://www.cdc.gov/growthcharts/clinical_charts.htm

☐ Sickle Cell Disease

☐ Congenital or acquired heart disease. Specify: _____

☐ Neurodevelopmental Disorder (e.g. cerebral palsy, muscular dystrophy). Specify: _____

☐ Medical-related technological dependence (e.g. trach, g-tube dependence, shunt dependence, chronic infusion dependence). Specify: _____

☐ Asthma/Reactive Airway Disease/Chronic Respiratory Disease Requiring daily medication for control

☐ Specify: _____

I, the referring provider, am the patient's PCP or other continuity provider and have arranged for the patient to follow up with me/my designee following Antibody infusion. For patients who have gone through the ED or Urgent Care center, the patient will update their PCP about his/her Antibody infusion in order to arrange follow up. If the patient does not have a PCP, I will refer him/her to an appropriate provider and ensure that follow up has been arranged. [Note: Ideal timing of follow up visit is approximately 7 days post-infusion.] **☐ **Indicates Provider Agreement**

I, the referring provider, have advised or will advise the patient that if his/her clinical status declines by the time of the infusion appointment, the treatment may no longer be appropriate for him/her. The patient's clinical status will be re-evaluated at the infusion center at the appointment time. If the patient is deemed in need of hospital care, s/he will be referred immediately. **☐ **Indicates Provider Agreement**

Signature: _____ **Date:** _____

Patient Name: _____ **DOB:** _____

The Infusion Center staff will communicate with the referring provider regarding such matters as treatment inappropriateness for patient, ultimate completion of treatment for patient, adverse events, etc.

Name of Referring Site: _____

Address: _____

Point of Contact: _____

Phone: _____ Fax: _____

Email: _____

Preferred mode of contact: ☐ Phone ☐ Fax ☐ Email

Patient's Primary/Continuity Care Provider (if different from above)

Office Name: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

There are two antibody treatments on our formulary. Patients will be scheduled for one or the other treatment based on availability of medications and logistics.

Information about both medications, Casirivimab+Imdevimab or *Bamlanivimab, including Fact Sheets and Manufacturer Instructions/Package Inserts for Healthcare Providers and for Patients/Parents/Care Givers, can be found at https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization#coviddrugs (scroll to section on Drugs and Biologic Products).*

Office-Use Only

☐ **Patient Qualifies for Antibody Therapy**
__ SARS-CoV-2 **Positive** by PCR
__ Within Treatment Window (< 10 days since symptom onset)
__ Qualifying Secondary Diagnosis:
__ Patient is not exhibiting need for new or increased O_2 therapy

** Antibody treatment window for patient this will terminate on _____ (date will auto-populate)

☐ **Patient Does Not Qualify for Antibody Therapy**
__ Patient is outside of treatment window; treatment window ended on _____
__Patient requires hospitalization due to a new or increased O_2 need
__Patient does not have a secondary qualifying diagnosis
__Patient's weight < 40 Kg